Preference is given to letters commenting on contributions published recently in the *JRSM*. They should not exceed 300 words and should be typed double spaced

Tracheostomy and the Spanish Civil War

As a Catalan and having a special interest in the subject, I agree with Dr Coni (March 2002 *JRSM*[1]) that most of the medical advances were made by the Republicans rather than the Nationalists. As he says, this was partly because of the more liberal atmosphere of the big Republican cities. Also the looser organization of their Medical Corps may have been more conducive to the development of new ideas. One topic not specifically mentioned by Dr Coni is management of the compromised airway and the performance of emergency tracheostomies. Last summer, I got hold of an excellent book entitled *Memories d'un Cirurgia* (Memoirs of a Surgeon)[2], written by the retired Catalan surgeon Moises Broggi who served in the International Brigades in one of the mobile hospitals. Before the Civil War he was one of the most promising young surgeons in Catalunya; afterwards he decided to stay in Spain but was denied all privileges in one of the university hospitals in Barcelona and could only practise privately for the rest of his professional career. His book, written in a very plain and simple style, became one of the best-sellers in the Catalan language in 2001. In it he describes his experience as a surgeon from 1936 to 1939 with the International Brigades from Brunete to Guadarrama, Belchite, Teruel and finally to the Battle of the Ebro. During the Battle of Belchite they noticed that casualties with severe facial injuries and fractures were dying shortly after triage, whilst waiting on the stretcher for definitive treatment. The deaths were usually due to aspiration of blood into the airway, so they decided to change their practice and perform emergency tracheostomies as initial action. This gave them the opportunity to suction the airway contents and rapidly restore respiration. After that, they stopped the haemorrhage and stabilized the patient, who could then wait to have his fractures reduced and debridement performed. This simple management sequence, resembling current methods of resuscitation, saved many lives during the subsequent battles of the Civil War and was adopted by Allied surgeons during the Second World War. It is sad that, for various reasons, we had to wait more than 60 years before the medical heroes in Spain received proper recognition.

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A clutch of new syndromes

In the ENT subsection of his paper (March 2002 *JRSM*[1]) Dr Le Fanu quotes a patient's description of sore ear, affecting a 'line of rigid muscle alongside the soft outer ear'. Whilst there exist fine muscles on the posterior, or cranial, surface the skin adheres closely to the anterior, or lateral, surface of the auricle, which has very little subcutaneous tissue[2]. Seemingly the patient refers to a fold in the elastic cartilage known as the antihelix.

The symptoms in this case closely resemble those of chondrodermatitis nodularis helicis. Histologically such lesions show focal degenerative change with surrounding perichondritis and overlying hyperkeratosis and acanthosis[3]. The usual treatment is simple excision, but a patient who declined surgery later told me how he had invented his own method to avoid discomfort at night—cutting a hollow into his foam pillow to reduce pressure on the ear.

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Diagnosis of parkinsonism

Dr Thant and colleagues (April 2002 *JRSM*[1]) describe 'a young man with parkinsonism' with the unusual features of no tremor, a poor response to levodopa, 'rapid progression of his symptoms and the presence of other neurological signs' and 'conduction abnormalities in the anterior visual pathways bilaterally' on visual evoked responses. They imply that the demonstration of diffusely increased signal from white matter on T2-weighted images, together with low signal in the basal ganglia and dentate nuclei (the latter shown by CT to be due to calcium deposits) clinched the diagnosis in a way the clinical features did not.

This is surely erroneous. I would suggest that they have not made a diagnosis, let alone explained, for example, the visual abnormalities. They do not comment, other than in the case report, on the significance of the white-matter disease. More fundamentally, as they point out, a small proportion of patients without intracranial disease or neurological deficits show calcification in the areas they describe. They attribute 'pyramidal signs, psychiatric symptoms, urinary incontinence, and epilepsy . . . in some patients' to a disease process which these changes might reflect, but the evidence that calcification is not simply an incidental finding in patients being investigated for these disparate conditions is largely lacking.

There is confusion in the references; however, I believe the authors are mistaken in their view that MRI 'is especially *useful* if . . . parkinsonian features are associated with other neurological features' (my italics). As regards papers claiming to demonstrate any utility of differentiating clinically similar conditions by imaging, it may be helpful to remind oneself that in parkinsonism the imaging features have been found to be less constant than the clinical characteristics (on which the studies have been predicated), and that imaging may tend to be least helpful when the clinical diagnosis is in doubt. As regards which patients with akinetic rigid syndromes will respond to treatment with levodopa or dopamine agonists—which would seem to be the greatest potential contribution of MRI or, for example, positron emission tomography—a worker with the latter method observed that 'informed trial and error seems as good a therapeutic approach as . . . imaging'[2].

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HIV-associated cardiomyopathy is not Keshan disease

In reply to Dr Cheng's comments (April 2002 *JRSM*[1]) I do not question the therapeutic role of selenium supplementation in patients with malnutrition (including selenium deficiency) and dilated cardiomyopathy in those with Keshan disease. However, the role of selenium deficiency in HIV-infected patients with cardiomyopathy is still controversial and controlled prospective clinical trials in this subset of patients are lacking. Cardiac and pulmonary complications of HIV disease are generally late manifestations and may be related to prolonged effects of immunosuppression and a complex interplay of mediator effects from opportunistic infections, viral infections, autoimmune response to viral infection, drug-related cardiotoxicity and nutritional deficiencies (selenium, vitamin B12, carnitine, growth hormone and thyroid hormone, frequently in combination)[2,3]. Because of its multifactorial pathogenesis, HIV-associated cardiomyopathy should not be compared to Keshan disease, since they are independent nosological entities from both a pathogenetic and a clinical point of view.

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Public and occupational health

Walter Holland's essay on public health (April 2002 *JRSM*[1]) is timely and one hopes that the Department of Health will act upon it in order to avoid repeating the mistakes of the past. Even if his suggestions were acted upon, however, an important cause of ill health will remain to be dealt with. Occupational disease is still a cause of substantial morbidity and not inconsiderable mortality[2]. Individuals do not transmute into other beings when they go to work; they carry with them wherever they go the conditions that are due to their occupation, their environment, their personal habits, their genes, or whatever combination of these is ultimately responsible. To separate occupational health from the mainstream of healthcare is thus not only illogical but also inefficient and ineffective. There is no remit for any of the new tiers of NHS administration to consider the role of occupation as a determinant of disease among the populations for which they are responsible and this omission urgently needs repair. To rely upon the Health and Safety Executive to provide the necessary framework within which this can be done is fanciful, not because HSE does not have excellently qualified people, but because it does not have nearly enough physicians and nurses or enough money to do so, nor does it have access to other parts of the health service.

NHS Plus is heralded as a means by which occupational health services can be provided throughout the country—another fanciful notion. The occupational health services within the NHS provide a service to their own trusts and sometimes to outside bodies, but there is no guaranteed uniformity of standard; there are too few consultants and trainees, and too few nurses, to provide anything like a comprehensive service on a large scale. Moreover, there is no money to correct any of these deficiencies other than what can be raised by departments carrying out contract work—an example of a dog chasing its tail in ever decreasing circles with the result we can all imagine.

Now is the time for the Department of Health to seize the opportunity to establish a health service that is truly comprehensive and which deals with *all* aspects of health and disease. All that is required is the will, the money and some vision. Oh dear. . .

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